California Strategic Plan for Suicide Prevention: Every Californian is Part of the Solution

Recommendations of the
Suicide Prevention Plan Advisory Committee to the
California Department of Mental Health

Draft for Review
January 11, 2008

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Part 1: The Problem and the Challenge

Suicide is the tenth leading cause of death in California. The tragedy of suicide is that it is largely preventable. Suicide was once a taboo subject, however since it was recognized as a major issue of public health and mental health it has become a subject of much public discourse.

National suicide prevention efforts have increased momentum over the last decade. In 1996, the World Health Organization urged nations to address suicide. As a result, in 1999 the United States convened a national public/private partnership to address suicide that resulted in the Surgeon General's "Call to Action to Prevent Suicide." Following this, in 2001 the Department of Health and Human Services developed a National Strategy for Suicide Prevention that calls upon each state to develop a comprehensive suicide prevention strategy. To launch this endeavor in California, the Suicide Prevention Advocacy Network of California (SPAN-CA), in conjunction with suicide prevention experts and mental health consumers, developed its California Strategy for Suicide Prevention, which recommended objectives for implementing the 11 goals of the National Strategy. This *California Strategic Plan for Suicide Prevention* builds upon the initial plan developed by SPAN-CA.

One of the objectives of the national "Healthy People 2010" initiative is to reduce the suicide rate nationally to no more than 4.8 deaths per 100,000 population by 2010. The California Department of Public Health published the Healthy California 2010 Progress Report as part of its participation in this national effort (Table 1).

Table 1. California's progress toward Objective 18-01 of the Healthy People 2010 Initiative[12] (California Department of Public Health)

	California Rate (2004)	Is CA Meeting Target?
HP 2010 Target		**4.8**
Overall	9.4	No
Males	14.7	No
Females	4.5	Yes
Whites	13.3	No
Asians	6.5	No
African Americans	5.5	No
2+ races	5.1	No
Latinos	4.7	Yes

This *California Strategic Plan for Suicide Prevention (the Plan)* is designed as a blueprint for statewide and local action to reduce suicide death and suicide behaviors, and reflects a commitment and an expectation to meet and then exceed the national target identified by Healthy People 2010. The Plan is intended to serve as a resource for policy makers, program managers, providers, funders, and other individuals or organizations to bring systems together to better coordinate existing prevention efforts and to enhance needed prevention, intervention and post-intervention ("post-vention") services. To achieve the goal of saving thousands of lives, every Californian needs to be part of the solution.

This Plan is designed to be a dynamic document that will be periodically reassessed with adjustments or additions made as appropriate to reflect evolving needs and circumstances in California.

The Magnitude of the Problem

In 2004, 32,439 suicides were reported nationally, which includes 3,364 Californians (Centers for Disease Control and Prevention [(CDC); California Department of Public Health (CDPH)]. This is the equivalent of nine lives lost

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[1] Listed are age-adjusted death rates. Rates are per 100,000 population.
[2] Rates for American Indian/Alaska Native and Pacific Islander populations are considered statistically unreliable due to the relatively small number of events (less than 20 annually) and are not included in this report.

every day in our state (California Department of Public Health (CDPH) 2004). More Californians died by suicide in 2004 (3,364) than homicide (2,489) (CDPH).

Many people who attempted or committed suicide had one or more warning signs (Table 2). Whereas risk factors for suicide are generally long term factors that are associated with a higher prevalence of suicide in the population, warning signs refer to more immediate signs or symptoms in the current state of an individual (Rudd et al., 2006). Recognition of warning signs has a greater potential for immediate prevention and intervention when those who are in a position to help know how to appropriately respond.

Table 2: Warning signs of suicide (Rudd et al., 2006)

Signs of acute suicidal ideation - Seek immediate help from a mental health professional or by calling 911 when any of the following are present:
- Someone threatening to hurt or kill themselves
- Someone looking for ways to kill themselves, e.g. seeking access to pills, weapons, or other means
- Someone talking or writing about death, dying, or suicide if this is unusual for the person

Seek help from a mental health professional or by calling 1-800-273-TALK should one or more of the following behaviors be witnessed, heard, or seen:
- Hopelessness
- Rage, anger or seeking revenge
- Acting reckless or engaging in risky activities, seemingly without thinking
- Feeling trapped – like there's no way out
- Increasing alcohol or drug use
- Withdrawing from friends, family, or society
- Anxiety, agitation, unable to sleep, or sleeping all the time
- Dramatic changes in mood
- No reason for living; no sense of purpose in life

Who Commits Suicide?

Suicide occurs among all age groups and across all socioeconomic, racial, and ethnic backgrounds. The causes of suicide are complex, and include an array of biological, psychological, social, environmental, and cultural risk factors (Table 3). Higher suicide rates than the general population are associated with specific demographic groups and factors such as mental illness, substance abuse, trauma history, social isolation, poverty, unemployment, marital status, family history of suicide, family discord, and legal problems [Centers for Disease Control and Prevention (CDC) Morbidity and Mortality Weekly Report (MMWR), Sept 7, 2007; Qin et al. 2003]. Stressful life events such as relationship problems, illnesses, divorce, a spouse's death, loss of employment, and academic problems may precipitate negative emotions that can lead to suicide.

Feelings of hopelessness and an inability to effect positive change in life is one of the most consistent psychosocial precursors to suicidal behaviors (Gray and Otto, 2001).

The impact of specific stressors among different individuals is subjective and likely to differ across age, sex, and cultural groups; for example a stressful event for an adolescent may have less of an impact on an older adult. It is more likely that the number of different stressors, rather than the nature of each one, is the more important predictor of the risk of suicide (Goldsmith, 2001). Childhood trauma and adverse experiences have an impact on suicide across the life span; one study found that they increased the risk of attempted suicide by two to five times that of the general population (Dube et al., 2001). The effect is particularly strong among adolescents for whom the trauma may be more immediate, such as physical or sexual abuse that is happening in the home (Dube et al., 2001).

Table 3: Risk Factors for Suicide (Suicide Prevention Resource Center)

Bio-psycho-social Risk Factors
• Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders, and certain personality disorders • Alcohol and other substance abuse disorders • Hopelessness • Impulsive and/or aggressive tendencies • History of trauma or abuse • Some major physical illnesses • Previous suicide attempt • Family history of suicide
Environmental Risk Factors
• Job or financial loss • Relationship or social loss • Easy access to lethal means • Local clusters of suicide that have a contagious influence
Socio-cultural Risk Factors
• Lack of social support and sense of isolation • Stigma associated with help-seeking behavior • Barriers to accessing health care, especially mental health and substance abuse treatment • Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution of a personal dilemma) • Exposure to, including through the media, and influence of others who have died by suicide

Within the general U.S. population, the rate of suicide is 11 per 100,000 population; in California, it is 9.2 per 100,000 (CDPH). Suicide is the tenth

leading cause of death among Californians (California Department of Public Health, 2004). Within the state, the highest suicide rate is in Humboldt County (19.8 per 100,000), and Los Angeles County had the lowest rate (7.1 per 100,000) (CDPH).[3]

Age

Nationally, the age group with the highest rate of suicide is older adults: the national rate for those over 65 is 14.3 per 100,000, and it is 37.4 per 100,000 among men over the age of 75 (CDC 2005).   In California in 2004, men over the age of 75 also had the highest suicide rate at 42.8 per 100,000 (CDPH). The highest age-specific death rate was among men over the age of 85 and women between 45-54 years of age (CDPH).

In 2004, suicide was the third leading cause of death among youth between 10-24 years of age across the nation (CDC, MMWR, September 7, 2007). Although the total suicide rate in this age group declined slightly during this period, there was a marked increase in suicide among specific groups, including females from 10-19 years of age and males between 15-19 years of age (CDC, MMWR, September 7, 2007).

Sex

Nationally, males are nearly 4 times more likely to commit suicide than females, representing nearly 80% of suicide deaths; however, women attempt suicide two to three times as frequently as men (CDC 2005). There is a similar trend in California. Suicide death rates for males are 3 times as high as those for females; however females are more likely to be hospitalized for self-inflicted injuries, primarily from poisoning or hanging (CDPH data).

Race and Ethnicity

Rates of suicide differ significantly between racial and ethnic groups. The age-adjusted[4] suicide rate among Whites is the highest across the nation, at 12 per 100,000, accounting for 84 percent of suicide deaths (CDC 2005).   Historically, African-Americans have had lower rates of suicide than other ethnic groups. However, the suicide rate among black males under the age of 35 has increased significantly over the last two decades, particularly among young men in the northern and western states (Willis et al., 2003).

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[3] County rates are based on the 3-year average number of deaths from 2003-2005, and using the mid-year population count from 2004 (CDPH data).

[4] Age-adjusted rate – when rates vary with age, and populations vary by their age distributions, age adjustment allows for comparison of rates between different populations with different age structure. The "effect of age" is no longer present in an age-adjusted rate. Age-adjusted rates are calculated using the age distribution of the 2000 US standard population, and they are usually expressed per 100,000 population.

Suicide is the leading cause of death among American Indians/Alaska Natives aged 15-24 years; from 1999-2004 young men in this population had a higher suicide rate (27.99 per 100,000) than any other racial and ethnic group of the same age (CDC 2005). Suicide is the second leading cause of death among Asian American/Pacific Islander youth from age 15-24 (CDC 2005). Data from the national Youth Risk Behavior Surveillance report found that more female Hispanic students reported suicidal ideation and behaviors than among their White or African-American female peers, with nearly one quarter reporting seriously considering suicide (CDC 2006, Youth Risk Behavior Surveillance, June 9). Several factors may influence these higher rates, including poor accessibility of mental health services, especially those that are culturally and linguistically appropriate. Different cultural attitudes about suicide and mental health may also play an influential role in help seeking behaviors.

In California, Whites had the highest rate of suicide followed by Asians, African Americans, Latinos/Hispanics, and people identifying as two or more races (Table 4). The highest age-specific suicide rate that is supported by reliable data is among Whites over the age of 85, and the lowest is among Latinos/Hispanics between 55-64 years of age (CDPH 2006). It is important to note that suicide rates for certain racial and ethnic groups, such as American Indians, Asians, Hispanics, and Pacific Islanders, may be under-represented due either to small population size or misclassification of racial and ethnic data on death certificates. The overall suicide rate for California (9.2 per 100,000) does include these population groups, however reliable California rates for these populations individually cannot be calculated due to the relatively small number of events (less than 20 per year). Suicide prevention research efforts need to consider ways to strengthen the data reporting and analysis for all population groups that may currently be under-reported.

Table 4. Suicide death rates (per 100,000) by sex and race/ethnicity in California, 2004.[5] (California Department of Public Health, 2006)

	Total	White	Asian	Black	Hispanic	2+ Races
Male	14.0	22.5	9.3	8.3	6.8	6.2
Female	4.5	7.2	4.4	2.7	1.6	3.0

Mental illness

As many as 90 percent of individuals who committed suicide had a diagnosable mental illness or substance abuse disorder (National Institute of Mental Health, 2003). Certain psychiatric diagnoses increase the risk of suicide substantially. Among individuals diagnosed with a major mood disorder, a spectrum which

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[5] Rates for American Indian/Alaska Native and Pacific Islander populations are considered statistically unreliable due to the relatively small number of events (less than 20 annually) and are not included in this report.

includes Major Depression and the Bipolar Disorders, the lifetime prevalence of suicide is approximately 20 percent (Rihmer and Kiss, 2002). The risk tends to be highest among those who have frequent and severe recurrences of affective episodes (Jamison 2001). Co-occurring substance and alcohol abuse exacerbates risk: in one national study, individuals diagnosed with Major Depressive Disorder who used drugs or engaged in binge drinking were significantly more likely to report suicidal thoughts and to attempt suicide than those with Major Depressive Disorder who did not use (SAMHSA, Office of Applied Studies, 2006).

Suicide is the leading cause of death among individuals with schizophrenia; nearly 6 percent commit suicide, with most suicide deaths occurring early in the illness, and up to 40 percent attempt suicide at least once (Palmer et al., 2005; Raymont, 2001). Having a history of a previous suicide attempt is a significant clinical predictor of committing suicide; other important factors of heightened risk include a family history of suicide, more severe symptomatology, and lack of appropriate treatment (Rihmer and Kiss, 2002; Jamison 2001). The latter includes accurate diagnosis and referral as well as treatment.

It is important to note the connection between mental illness and incarceration. In fact, nationally the number of individuals with mental illness who are in jails and prisons is higher than the number that is in psychiatric hospitals (Dumond et. al, 2003). Nationally, more than half of all prison and jail inmates have a mental health problem; a rate three times that of the general population (Lyons, 2007). Suicide is the third leading cause of death in California prisons (13 per 100,000) and the leading cause of death in the state's jails (52 per 100,000) (U.S. Department of Justice, 2005). The periods of highest risk for suicide are the first month of incarceration and the first few weeks after release from prison (Binswanger et. al, 2007; Pratt et. al, 2006; U.S. Department of Justice, 2005). Despite this risk, many jails and prisons do not have protocols for screening at booking (www.mces.org/suicide_prisons_jails.html). This problem is not limited to the adult corrections system; one study found that only 15.4 percent of adolescents in juvenile detention facilities who needed mental health treatment received appropriate care (Roberts, 2006).

Veterans

An analysis of data from national health surveys and the National Death Index from the middle 1980s to 1990s found that male veterans were twice as likely as the general population of males to die by suicide, especially those who were white, had less education, and had physical activity limitations (Kaplan et al., 2007). Data collected prior to Operation Enduring Freedom/Operation Iraqi Freedom estimated that suicide rates among veterans that were currently using Veterans Affairs (VA) facilities were 45 per 100,000 among those over the age of 65, and as high as 83 per 100,000 for those under age 65 (Department of Veterans Affairs, U.S. 2007). Extrapolating from more recent national data, the

U.S. Department of Veterans Affairs estimates that there are 1,000 suicides per year among veterans receiving care through the Veterans Affairs health care system, and as many as 5,000 per year among all living veterans (2007).   Some of the most at-risk groups include those with severe mental illnesses, and those with combat-related Post Traumatic Stress Disorder (PTSD), traumatic brain injury, traumatic amputation and/or disfigurement, military sexual trauma, and spinal cord injuries (2007).

Surveys of military personnel stationed in Iraq and Afghanistan indicate that as many as 17 percent met the criteria for major depression, generalized anxiety, or post traumatic stress disorder; this is significantly higher than rates among the general population (Hoge et al., 2004). Of those, less than 40 percent sought mental health care (2004). Furthermore, they were twice as likely to be concerned about being stigmatized and discriminated against as those who did not meet the criteria. These high rates of mental disorders and fear of stigma among those most in need indicate that suicide prevention planning must take into account the needs of veterans who have recently, or will soon be, returning from the active field of war.

Other populations

Estimates from national data and other research indicate that the suicide rates are higher in certain subgroups than the general population, e.g. individuals living in rural areas, those who are homeless, and those identifying as Lesbian, Gay, Bisexual, Transgender, or Questioning (LGBTQ); in the latter, especially among transition-aged youth (Advancing Suicide Prevention, 2005; Department of Justice, 2005; Eynan et. al., 2002; Heeringen & Vincke, 2000; Russell & Joyner 2001).   California-specific data reports are not available for these subgroups.

Rural states have the highest rates of suicide in the U.S., due to factors such as service access, access to guns and other means, poverty rates of poverty, and percentage of older adults in the population (Advancing Suicide Prevention, 2005). A study of homeless individuals found that 61 percent reported suicidal ideation, and 34 percent had attempted suicide; the rates were higher among women than among men, and were particularly high among people who had been homeless longer than six months (Langley et al., 2002). Furthermore, among homeless individuals, suicide rates are highest between 30-39 year olds, although co-occurring substance abuse significantly increases risk among older homeless individuals (Prigerson et al., 2003).

Data from the National Longitudinal Study of Adolescent Health found that lesbian, gay, and bisexual respondents had higher rates of suicidal ideation and suicide attempts than heterosexual counterparts (Silenzio et al., 2007; Russell and Joyner, 2002). The risk of suicidality may be particularly acute among adolescents: a survey of students in the 9th-12th grades found that over half of

the students identifying as gay, lesbian, or bisexual had thought about suicide and nearly 40 percent had made an attempt (Eisenberg and Resnick, 2006).

Suicidal Behaviors

Suicide is defined as the intentional taking of one's own life. It is the "final and most severe endpoint" along a continuum of self harming behaviors that includes self-injury with or without the intent to commit suicide (Muehlenkamp and Gutierrez, 2007). Suicide-related behaviors include self-inflicted, potentially injurious behaviors that may be related to suicidal intent, even if they do not result in injuries or that are a form of self harm that results in unintentional death (Silverman et al, 2007). It is important to be aware of the range of suicidal behaviors because self-harmful or injurious behavior without suicidal intent may indicate an increased risk of suicide in the future. The range may also include hidden methods not captured in the data such as lethal overdose of prescription or illegal drugs, or incidents such as when a suicidal individual engages in a life-threatening behavior to the degree that it compels a police officer to respond with deadly force (commonly referred to as "suicide by cop").

Means of Suicide

Most suicide deaths tend to be among individuals who are older, male, and who use more lethal means, such as firearms (Harvard School of Public Health, n.d.). A study of individuals who attempted suicide found that almost half of the subjects reported that less than one hour passed between their decision to commit suicide and the actual attempt; another 24 percent indicated it was less than five minutes (Simon et al., 2001). Ease of access to lethal means is an important factor that can put time between the impulse to commit suicide and the act itself, allowing opportunities for warning signs to be recognized and interventions to occur.

Certain means of suicide are particularly lethal by nature, such as firearms. The Centers for Disease Control and Prevention's National Violent Death Reporting System (NVDRS) found that in 82 percent of suicide by firearms among youth under 18, the firearm belonged to a family member, underscoring the importance of attention to safe storage of firearms in the home (2007). When there are gaps between systems that need to share information in the interest of public safety, lives can be lost. The Report to the President on Issues Raised by the Virginia Tech Tragedy (White House, 2007) concluded that in many states, laws and practices do not uniformly ensure that information on persons restricted from possessing firearms is appropriately captured and available to the National Instant Criminal Background Check System. The same report also found that efforts to coordinate between systems is challenged by confusion about confidentiality laws and the type of information that can be shared between providers, especially in different systems such as mental health, hospitals, and education.

Nationally, firearms are used in 58 percent of suicide deaths among males, whereas the most common method for females is poisoning (37.8 percent) (CDC 2005). According to the Centers for Disease Control and Prevention, a poison is any substance that is harmful to the body when eaten, breathed, injected, or absorbed through the skin. Poisoning occurs when too much of some substance has been taken; the definition does not include adverse reactions to medications that were taken correctly.

Although firearms remain the most common means of suicide, the use of other lethal means has increased, particularly among certain age and sex groups. Poisoning deaths are mostly attributable to substance abuse, primarily of prescription and illegal drugs (CDC, MMWR, February 9, 2007). Poisoning accounted for 28 percent of the increase in the national suicide rate between 1999-2004 (CDC, MMWR, December 14, 2007). Nationally, the number of poisoning deaths classified as unintentional is second only to motor vehicle crashes (CDC, MMWR, February 9, 2007). The Centers for Disease Control and Prevention acknowledges that establishing whether a poisoning death was intentional or not is difficult and misclassifications may occur. This underscores the importance of partnering with medical examiners and coroners to ensure that causes of death are reported as accurately as possible.

From 1999-2004, the rate of suicide by hanging/suffocation increased, especially among adults aged 20-29 (31.7 percent) and 45-54 (48 percent) (CDC, MMWR, December 14, 2007). Among females between 10-24 years of age, the rate of suicide by hanging/suffocation increased significantly; this method accounts for 71.4 percent of suicides among females between 10-14 years, 49 percent between 15-19 years, and 34.2 percent between 20-24 years of age (CDC, MMWR, September 7, 2007). Addressing access to controlled substances and firearms is one way to prevent many suicides. However, the means to commit suicide by hanging/suffocation are generally accessible and would be difficult to control, suggesting that prevention programs need to address access to lethal means in concert with psychosocial interventions that target groups at high risk.

In California, the leading means of suicide among males is firearms (47 percent), followed by hanging or suffocation; these methods combined account for 68 percent of all California suicides (CDPH). Poisoning is the leading means of self-inflicted, non-fatal injury, with alcohol and drug overdose accounting for 77 percent of all poisoning incidents in California (CDPH). The main method of suicide for females is poisoning (39 percent) (CDPH).

The Costs of Suicide and Self-Inflicted Injuries

The emotional cost of suicide has both immediate and far-reaching impacts on families and communities. It is estimated that each suicide immediately impacts at least six other people (McIntosh, 2006). In addition to grieving the loss of the

individual who took his or her own life, survivors – such as family members, caregivers, and friends – may also be at increased risk of suicide. Further, the stigma associated with suicide may lead to reluctance to talk about the problem and to seek out social supports and mental health services.

Beyond the human suffering and emotional toll of suicide and self-injuries on families and communities, there are also financial costs related to lifetime lost productivity for individuals who took their lives and for the medical cost of those who survive a suicide attempt. To estimate these costs, formulas have been derived based on costs incurred by victims, families, employers, government programs, insurers, and taxpayers (SPRC, Methods Fact Sheets). Estimates of medical-related costs related to self-injuries take into account hospitalizations and follow up treatment, coroner and medical examiner costs of completed suicides, transport, Emergency Department, and nursing home costs. Productivity estimates take into account lost wages, fringe benefits, and costs related to permanent or long term disability. Using this formula, the average medical cost per suicide in California is $4,781, and the average work loss is $1,219,333 (SPRC, California Suicide Prevention Fact Sheet). Collectively, these result in an annual cost of over $92 million (Corso et. al., 2007).

The economic burden of suicide is spread throughout a variety of systems, including education, hospitals, primary care, mental health, and corrections. In 2004 alone, there were over 535,000 emergency room visits across the nation for self-inflicted injury (National Center for Injury Prevention and Control).

Part 2 – Strategies for Suicide Prevention

Suicide prevention encompasses a range of prevention, intervention and post-vention strategies or approaches to reduce the incidence of suicide and suicidal behaviors. Suicide prevention includes efforts to foster resiliency, enhance protective factors for individuals and within the community, decrease risk factors, provide follow-up care for those who have survived a suicide attempt, and reduce the impact of suicidal behaviors on family, friends, and communities. Suicide prevention also includes research leading toward further understanding of racial, ethnic, cultural, social, and biological factors that are protective factors that promote help-seeking behavior or that contribute to reducing risk factors. Finally, suicide prevention encompasses efforts to evaluate and improve programs and interventions designed to reduce the incidence of suicidal behavior (National Strategy for Suicide Prevention, 2001; California Strategy for Suicide Prevention, 2005; Maris et. al. 2000).

Strategies to Prevent Suicide

There is no one cause of suicide. The causes are likely to vary among age, sex, and racial and ethnic groups, and are influenced by complex interactions between biological, psychological, social, and cultural factors (Goldsmith et al., 2002). Researchers have been able to identify protective factors that can reduce the likelihood of suicide by counterbalancing some of the risk factors (Table 5). Prevention strategies also focus on enhancing resiliency to the factors that can increase the risk of suicide.

Table 5: Protective factors for suicide (National Strategy for Suicide Prevention, 2001)

- Effective clinical care for mental, physical, and substance abuse disorders
- Easy access to a variety of clinical interventions and support for help seeking
- Restricted access to highly lethal means of suicide
- Strong connections to family and community support
- Support through ongoing medical and mental health care relationships
- Skills in problem solving, conflict resolution and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self preservation

Examination of populations with lower suicide rates can point to protective factors and possible focuses for prevention strategies. Different rates of suicide among countries may be explained by social (including religious), political and/or economic factors (Goldsmith et al., 2002). According to data from the World Health organization, the highest suicide rate in the world is in Hungary (66 per

100,000) whereas the lowest is in Mexico (2.5 per 100,000)[6]; differences between the countries in rates of depressive disorders, alcohol consumption, proportion of older adults, levels of social isolation, and religiosity may all play a role in the rate of suicide (Goldsmith, 2001). In the U.S., suicide rates among African American women, particularly in middle age, are very low (Goldsmith, 2001). Sociocultural differences between population groups and between individuals, such as social connectedness, family relations, marital status, parenthood, and participation in religious activities and beliefs (including negative moral attitudes toward suicide), may all be important underlying factors (Goldsmith et al, 2002).

Integration of Systems and Resources

Recognition of the warning signs of suicide must be supported by knowledge of how to respond and where to get help. Fragmentation of systems presents a fundamental challenge of effective access and continuity of care that can cost lives (Raingruber, 2003). Readily available and up-to-date directories of local resources that offer suicide prevention and intervention services and supports would increase knowledge of access points among the individuals at risk, the general public, and providers in different systems.

Models of collaboration need to be developed to ensure that professionals from different disciplines and systems that have important roles in the process of evaluating, treating, and preventing suicidal behavior can communicate and coordinate activities. As an example, in San Francisco the recognition that 70 percent of suicide deaths were from traumatic self-injury (i.e. versus poisoning), along with the fact that two-thirds of those who died by suicide were in psychiatric treatment at the time of their death, led to the implementation of joint psychiatric and trauma service review teams at San Francisco General Hospital (NVDRS and Suicide, SPRC Fact Sheet; Schecter et al, 2005). The suicide review teams created a feedback mechanism between different systems to improve care and ultimately prevent suicides in the city. Another collaborative model to address a life-or-death problem involving multiple systems is child death review teams. These teams bring together a multidisciplinary group that includes medical examiners and coroners, to determine cause of death, improve surveillance, and address concerns about the underreporting of child homicides (Durfee et al., 2002). Since the factors surrounding a suicide death are often complex and the stigma of suicide may influence the accuracy of reporting, review teams can solidify accuracy and validity and provide opportunities to identify systemic changes to prevent future deaths (Timmermans, 2005).

Many effective practices integrate suicide prevention into existing community settings and services and utilize key points of contact or "gatekeepers" such as

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[6] It is important to note that this data should be interpreted cautiously, as it is compiled from various sources and studies that may have employed different criteria and methods. This may result in under-reporting of actual suicide deaths.

community health workers or promotoras, school staff, primary care providers and staff, and home visitors with Meals on Wheels and other providers with services for older adults (Kataoka et. al., 2007, p. 1342; Muehlenkamp & Gutierrez, 2007). These strategies are particularly effective for groups that are underserved by the traditional mental health system and are more likely to be identified by or seek help through other community supports. Some strategies for integrating systems for more effective response to suicide include co-location of mental health services and primary care services, integrating mental health services into school-based clinics, and cross-discipline suicide assessment and intervention training. Approaches such as routine screening as standard protocol for early identification of risk factors in primary care settings can be expanded and considered for other systems (Stroul, 2007).

To effectively prevent suicide, each county needs to have a well-coordinated crisis response system. This system should be able to respond to acute, emergency situations involving emergency department and hospital staff, mental health providers, and law enforcement personnel. It should also include help lines and mobile outreach teams so that help is readily available when, and where, needed. Individuals transitioning between systems, such as those discharged from inpatient care may be at high risk of suicide, and protocols for follow-up care and effective referral to support services are important to ensure continuity of care that can save lives. Safety plans for facilities, such as school campuses, support preparedness to effectively respond to a crisis, including suicide.

One of the most promising ways to prevent suicide and suicidal behavior is through recognition of early signs of mental health problems stemming from depression, loneliness, and other needs (Goldsmith et al, 2002). Psychosocial therapy that strengthens problem solving skills can help to address the feelings of hopelessness and of being overwhelmed and unable to change negative situations that lead to increased risk of suicide (Gray and Otto, 2001). Due to the strong link between severity or recurrence of episodes of serious mental illness and risk of suicide, consistent and appropriate treatment is crucial to suicide prevention (Jamison 2001). In addition to risk factors for the general population, individuals diagnosed with a serious mental illness have other specific risk factors such as unemployment, social isolation, severity of symptoms, and numerous relapses (Raymont, 2001). Additionally, suicide risk is concentrated in periods of time such as right after initial onset, early in the illness, and immediately after a hospital discharge (Deisenhammer et al., 2007; Raymont, 2001). Individuals are particularly vulnerable the week after discharge, suggesting that inpatient discharge procedures should include a solid plan for continuity of care (Deisenhammer et al., 2007). Individuals who have previously attempted suicide are at significantly higher risk, for example up to 56 percent of people that died by suicide who had bipolar disorder had at least one previous attempt (Rihmer and Kiss, 2002). Recognizing the importance of mental illness

in suicide rates and improving early detection and intervention should be critical components of suicide prevention strategies.

Suicide Prevention Help Lines

Suicide prevention help lines are an effective way for people in crisis to reach out for help, and those that use them report that they are helped by the calls. Surveys of individuals that have used help lines indicated that measures of the level of emotional distress and suicidal ideation are decreased by the end of the calls (Gould et. al., 2007; Kalafat et al., 2007). However, crisis help lines that are not accredited may differ in whether suicide risk assessment procedures are completed, and in thoroughness of the assessment, which can result in uneven quality of response across locations (Kalafat et. al, 2007).

The National Suicide Prevention Lifeline (800-273-TALK) is a 24-hour, toll-free help line funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). It consists of over 125 accredited crisis centers in 45 states around the country. When a caller accesses the Lifeline, their call is immediately routed to the affiliated call center that is closest to the area code of the phone number from which they are calling. Callers can remain anonymous, minimizing concerns about stigma that may inhibit people in need from seeking mental health services elsewhere. To address the needs of callers who do not speak English as their primary language, the Lifeline operates a network of nine Spanish language call centers across the nation, two of which are in California, and all Lifeline call centers have free access to a live language interpretation service that includes over 170 languages (Suicide Prevention Lifeline information).

Call centers that are members of the National Suicide Prevention Lifeline undergo an accreditation process to ensure that responders are trained in evidence-based risk assessment procedures, and that these are consistently administered to all callers. The criteria for accreditation standards were developed with the involvement of national and international experts in suicide prevention to ensure incorporation of the latest research and information (Joiner et al., 2007). Ongoing technical assistance is also provided to member call centers to ensure continuing, uniform quality across the network.

Recently the Department of Veterans Affairs and SAMHSA collaborated to co-sponsor the Veterans Affairs Suicide Prevention Lifeline. Individuals may now call the Lifeline number (800-273-TALK) and identify themselves as a veteran. They are immediately transferred to a helpline staffed by mental health professionals at a Veterans Affairs (VA) facility in upstate New York, who will have information about VA resources throughout the nation. This is an important first step in linking veterans who are in crisis to specialized mental health services that target their needs.

Currently there are eight help lines in California that are accredited by the National Lifeline to provide suicide prevention services. Anyone in California can call the National Lifeline number, but they may not always reach a call center that is in California. MediCal requires each county mental health department to operate a 24-hour crisis line, however crisis lines may not include suicide prevention assessment and intervention.

Data from the National Lifeline-accredited Didi Hirsch Community Mental Health Center indicates that in fiscal year 2006-2007, 80 percent (19,553) of calls from California were answered within the state, and 20 percent (4,273) were answered by help lines in other states. California-generated calls that come from counties that do not have a lifeline call center are routed to other counties based on the availability and capacity of their help lines (e.g., staff availability, a busy line, billing limitations). In a typical day, in addition to handling all the local calls from the Los Angeles area, the Didi Hirsch Community Mental Health Center took calls from Santa Cruz, Fresno, Shasta, Sacramento, San Mateo, Kern, and Napa counties. When the Didi Hirsch Center cannot answer a call, such as when all its lines are busy, most are routed to a call center in Nebraska.

There is a need to increase the capacity of suicide prevention help lines in California so that callers from every county can access a local, accredited call center. The concern about the limited in-state capacity of accredited help lines is that if calls are not answered locally, responders may not be able to refer individuals in crisis to local resources to get follow-up services and treatment. A long-term commitment to continuity and quality is needed to enhance the availability and capacity, including multiple language capacity, of help lines.

Approaches to Target High Risk Populations

Due to the unique characteristics of different age or ethnic groups, and the disparities of access to services these groups currently experience, effective approaches to suicide prevention need to develop outreach and intervention strategies that target these groups (Pragmatic Considerations of Culture in Preventing Suicide, 2004; Luoma et al, 2002).

Peer Support and Self Help

Individuals who have survived a suicide attempt need a support system and tools to facilitate self assessment of risk following attempts, self harm behavior, and coping with suicidal thoughts. Similarly, survivors of the suicide of a friend or loved one also benefit from education and support from peers and other survivors. Organizations like the California Network of Mental Health Clients and the National Alliance on Mental Illness are important sources of support, advocacy, and information for mental health system clients and their family members (National Strategy for Suicide Prevention). A growing body of literature substantiates the effectiveness of services and supports delivered by individuals

with lived experience, such as peer support models and consumer-operated services (Van Tosh, L. and del Vecchio, P., 2000; U.S. Dept. Of Health and Human Services, 1999). There are many national and in-state web-based resources and technical assistance centers that provide peer training and education materials to individuals and organizations.

Peer support and engaging those with lived experience of suicide, including families, friends, and survivors, can be a powerful tool to address local suicide issues. Humboldt County has the highest suicide rate in the state. This may be due to limited available services or access to services due to geographic isolation, significant Native American population, and other factors. Recently, the California Network of Mental Health Clients organized Suicide Alternatives Workshops that bring together survivors of suicide attempts, family and friends of those who have died of suicide, clergy, mental health clients, mental health professionals, and physicians to discuss the problem of suicide in their county. The purpose of the workshops is to provide community education and outreach, peer support, and to develop recommendations for a local suicide prevention plan.

Another promising practice is developing web-based self help programs, a cost effective approach to providing accessible, anonymous information and resources to those who have access to the internet. Examples include the consumer technical assistance centers funded by the Substance Abuse and Mental Health Services Administration, such as the National Empowerment Center (www.power2u.org). Another example is "Beyond Blue," the national depression intervention initiative in Australia that hosts a website that offers self assessment tools and resources to find mental health care, post notices on a bulletin board, and learn more about research (www.beyondblue.org).

Older Adults

Although up to 75 percent of older adults visited their primary care physician within a month of their suicide, the majority of these older adults were not receiving mental health treatment. This is often due to stigma and a lack of recognition of depression and warning signs of suicide among providers of services to older adults, which are often mistaken for a normal part of aging (Bartels et al., 2005; NIMH, 2003).   Multiple evidence-based programs have been developed that target older adult mental health; currently ten programs are listed on the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry for Evidence-Based Programs and Practices (NREPP).   Most of these programs contain components for outreach, engagement, and education that are embedded within existing community structures and services that older adults commonly use. Often this involves integrating services into primary care, co-locating health and mental health services, and expanding the capacity of programs at senior centers and Area Agencies on Aging, including home-based services.

For example, the Prevention of Suicide in Primary Care Elderly Collaborative Trial (PROSPECT) combines treatment guidelines for depression in primary care settings with comprehensive care management for older adults diagnosed with depression (Suicide Prevention for Older Adults, Older Americans TAC; NREPP). Trained clinicians work closely with the primary care provider, the older adult patient, and their family around treatment protocols and education. Outcomes of this program include statistically significant reductions in suicidal ideation when compared with a control group (Bruce et al., 2004).

Unique barriers to implementation need to be addressed to ensure that older adults have access to quality suicide prevention and treatment services. Medicare and insurance industry partners need to address reimbursement issues that may create barriers to mental health services for older adults (Bartels, et al. 2005; Karlin and Humphreys, 2007)). The Program of All Inclusive Care for the Elderly (PACE) provides a model for coordinating Medicaid and Medicare financing with community-based social, mental health, and primary health services to provide an alternative to nursing home care (NREPP, www.nrepp.samhsa.gov). An interdisciplinary treatment team oversees the implementation of the individualized treatment plan for each older adult enrolled in the program. Results from this program include decreased use of high end, acute services, better quality of life and health status, and lower mortality rates.

The gatekeeper model is an example of a program that has the potential to be effective with multiple population groups. The model provides training to a broad range of important community contacts that are not traditional health or mental health providers about warning signs and how to refer people for help. For example, gatekeeper programs that target older adults may provide training for employees of local businesses and community organizations, postal carriers, bank tellers, meter readers, and others who are likely to encounter older adults in the community or in their homes. Studies have found that the gatekeeper model is successful at identifying and referring individuals to services who are not likely to seek help on their own (Depression and Anxiety, Older Americans Technical Assistance Center, SAMHSA).

Racial/Ethnic and Cultural Communities

The Surgeon General has reported significant disparities in access, availability, and quality treatment for racial and ethnic minorities as compared to whites (U.S. Department of Health and Human Services, 1999). These disparities are evident in the paucity of culturally and linguistically appropriate services and supports, including inconsistency in language access in services, help lines, and informational materials, and in the fact that many evidence-based practices have not been tested among diverse population groups. Research has found disparities not only in access to treatment, but also in quality and appropriateness of treatment once it is obtained. Cultural differences matter

substantially in this regard. For example, African Americans are more likely to be incorrectly diagnosed than white Americans, and are more likely to leave treatment earlier than whites (1999). This may be due in part to the possibility African Americans may present their symptoms differently from what most clinicians are trained to expect, potentially leading to diagnostic and treatment planning problems (1999). Fears of racism along with the stigma and discrimination of mental illness are important factors, and African Americans are substantially less likely than whites to have access to treatment providers who are also black (1999). Other population groups, such as immigrants and refugees, may have heightened risk of suicide and mental illness due to factors such as intergenerational conflicts related to acculturation, family pressures related to academic achievement, and adverse experiences from the home country, including war, torture, and genocide.

California is a diverse state: data from the 2000 census indicated that the majority (53.3 percent) of California's population identified as non-white, and 40 percent spoke a language other than English at home (Lopez 2002). A quarter of the population was born outside of the U.S.: 67.2 percent of Asians are foreign born, and 43.9 percent of Latinos are foreign born (Lopez, 2003). Most (a combined 63 percent) of these populations are concentrated in the San Francisco Bay Area and Los Angeles (2003). In order to address the needs of this diverse population, mental health and suicide prevention services need to identify and develop culturally competent, targeted approaches for successful outreach, engagement, and appropriate diagnosis and treatment.

Some strategies that are promising include engaging diverse communities through natural community leaders and helpers such as faith leaders and community health workers (such as promotoras) or indigenous healers. If trained to recognize and respond to warning signs of mental illness and suicide risk, these individuals are in a position to promote early intervention for individuals at risk who may not otherwise seek professional help. Successful approaches have involved a process of community engagement to determine the strategies used, for example, through community participatory action research methods that increase validity, acceptability, and sustainability within communities (NIMH 2004). Effective approaches tend to be specific and targeted and culturally relevant, including the role of families, the church, traditions, and other values and attitudes that include perspectives on suicide and mental illness (NIMH 2004).

To address disproportionately high suicide rates in Native American communities, particularly among youth, inclusive approaches have been developed that involve the whole community. Although few evidence based practices have been tested in Native American communities, tribes are actively engaged in developing and/or adapting best practices (U.S. Dept. of Health and Human Services, Indian Health Service website; One Sky Center, 2006). For example, the Jicarilla Apache of Northern New Mexico developed a community

intervention that involves tribal leadership, community members, youth, clinicians, university researchers, and the Indian Health Service that resulted in a 60 percent decline in suicides over a 10-year period (U.S. Dept. of Health and Human Services, 2005). Additionally, programs in Phoenix and Alaska have implemented successful suicide prevention strategies targeting Native Americans that include open access models and training that includes not only suicide prevention and intervention, but also culturally-specific, traditional approaches and perspectives (U.S. Dept. of Health and Human Services, 2005).

It is also important that mental health and health providers reflect the diversity of the population they are charged with serving, including language diversity, so that people of diverse cultures, ethnicities, and languages can feel comfortable seeking services that they are confident will be able to appropriately and effectively address their needs. Although some models for culturally and ethnically appropriate services exist, there is a need for more research about effective models, and to test existing practices for their effectiveness among diverse populations.

Adolescents, Youth, and Young Adults

Nationally, many more children and youth are in need of specialized mental health services than actually have access to them (Stroul, 2007). Several strategies have been recommended to improve service delivery and training of providers, particularly in primary care, who do routinely come into contact with adolescents and youth who may be at heightened risk of emotional disorders or suicidal behavior. Examples are co-location and training of child mental health specialists to work in primary care settings, enhanced pre-service training in medical school and for providers in practice (Stroul, 2007).

Because school is where many youth spend a large part of their days, school staff is in the position to detect the early stages of mental health problems and potential suicide risk. However, many school personnel are not trained or equipped to deal with these problems, they may not know how to respond, or the school may not have readily accessible mental health services to provide support (California Dept. of Education, 2003). By 2000, 77 percent of schools in the United States had implemented a suicide prevention program (Brener et. al, 2001; Small et. al., 1995 as cited in Kataoka et. al, 2007). The most promising of these provide gatekeeper skills training on suicide prevention and warning signs (SAMHSA, 2007). Furthermore, effective training involves identification of and referral of students at risk, as well as strategies for how to address risk factors directly (California Dept. of Education, 2003). They also use early intervention strategies such as screening instruments that detect mental health problems or warning signs of self-harm and suicidality (Kataoka et. al., 2007, p. 1342; Jamison, 1999). These programs can be successful in helping students who might not otherwise seek help on their own and linking them to mental health

services. They can also be successful in developing protocols to handle a suicide crisis that minimizes the chances of a contagion effect.

It is important to implement strategies that promote protective factors against suicidal behavior in young people. One study found that adolescents identifying as gay, lesbian or bisexual reported significantly higher levels of suicidal ideation and suicide attempts than their heterosexual counterparts (Eisenberg and Resnick, 2006).   This study also found that the heterosexual students reported higher levels of protective factors such as family connectedness, adult caring and involvement, and feeling that the school was a safe place. School programs can enhance the capacity to build resiliency among students by adopting curricula that teach problem solving skills, conflict resolution, and nonviolent handling of disputes.

The tragedy of events at Virginia Tech in April 2007 raised national awareness of the need for earlier and better comprehensive mental health services on college campuses. Some of the key findings of the Report to the President on Issues Raised by the Virginia Tech Tragedy (June 13, 2007, Washington, D.C.) included:

- Sharing of critical Information between education officials, healthcare providers, law enforcement personnel, and others faces substantial obstacles because of confusion about confidentiality laws;
- There is a need for parents, students, and teachers to learn to recognize warning signs and encourage those who need help to seek it;
- Effective coordination of community service providers who are sensitive to the interests of safety, privacy, and provision of care is needed to meet the challenge of adequate and appropriate community integration of people with mental illness;
- Full implementation of emergency preparedness and violence prevention plans is needed to address school and community violence.

A survey of University of California students conducted in 2000 revealed that 9 percent of students had serious suicidal ideation and up to 80 percent of those with suicidal ideation had not received mental health services (UC Student Mental Health Committee). Another University of California study (2006) found that from 2000-2005 the number of students taking psychotropic medications and the number of mental health visits to student health centers increased by more than 50 percent, with a significant rise in crisis visits. In addition, incidents of suicidal behavior, including attempts, among U.C. students increased during the same time period. Some of the students identified in the report as at highest risk include graduate students, LBGTQ students, international students, and racially and ethnically underrepresented students (UC Student Mental Health Committee, 2006).

Increasing the availability of mental health and suicide prevention services on college campuses, and between campuses and the services offered in their surrounding communities, facilitating critical links between campuses and the communities they serve, are important steps in preventing suicide among young adults.

Recognizing the importance of this issue, the California Department of Education and the University of California Regents, among others, have recommended implementation of strategies to address suicide and suicidality among youth and young adults (California Department of Education, 2005; University of California, 2006).

Veterans and the Military

Active military and veterans are at disproportionately high risk of mental illnesses such as Post Traumatic Stress Disorder (PTSD), and of suicide (Hoge et al., 2004; U.S. Department of Veterans Affairs, 2007). Strategies to address suicide prevention among veterans must take into account the particular prevalence of concerns about stigma and discrimination that constitute barriers to needed care. They must also address access to mental health services, especially for veterans that may live far way from the nearest Veterans Affairs Health Center. The volume of need for mental health services among the thousands of veterans returning from Iraq and Afghanistan must also be met. Although the Veterans Administration (VA) has been working to increase the availability of counseling services for veterans, the number of new hires for Veterans Affairs-operated community-based health centers around the nation (Steverman, 2007) will not sufficiently fill the gaps.

Beginning in fall 2003 the U.S Department of the Army convened Mental Health Advisory Teams (MHAT) to annually review data on mental illness and suicide among deployed soldiers, assess quality and access to mental health care, and provide recommendations for improvements (U.S. Dept. of the Army, 2006). One example of how the MHAT has strengthened suicide prevention in the Army is that its recommendations led to employment of the Army Suicide Event Report, a reporting and tracking mechanism that collects extensive data about suicides and attempts, to Army operations in Iraq (2006). The development of the Veterans Affairs Suicide Prevention Lifeline (800-273-TALK) is another step toward beginning to address the specific mental health needs of veterans.

The Air Force Suicide Prevention Program is a promising practice that was developed in response to a rise in the rates of suicide in the Air Force from 1990-1995 (U.S. Dept. of Health and Human Services, Best Practice Initiative, 2002). It includes components that address stigma, the need for awareness about suicide, and continuity of care. Key components include:

- Strong messaging from the Air Force Chief of Staff that promotes social support between officers, supervisors, and coworkers, and the value of seeking mental health services early
- Educating community members by requiring personnel to receive suicide prevention training, and encouraging each Air Force installation to develop "home grown" training programs that reflect their local community
- Improving surveillance through a web-based database that collects demographic, risk factor, and protective factor data; and development of a Behavioral Health Survey that also provides unit-specific feedback to commanders to help tailor intervention to each community
- Development of critical incident stress management teams at each installation to respond to units that are impacted by events such as deployments, natural disasters, and other possibly traumatizing events
- Integrated delivery of human services at each location to ensure that chapel programs, mental health services, Family Support Centers, Child and Youth programs, Family Advocacy programs, and Health and Wellness centers are available and coordinated for each base location.

Results of the program include a statistically significant drop in suicide rates for three consecutive years; more than 50 percent reduction from the lowest rate on record prior to 1995 and an 80 percent drop from the peak rates of the 1990s (U.S. Dept. of Health and Human Services, 2002).

Given the magnitude of the problem of suicide among veterans, it is critical that the military and the reserves are partners in the implementation of the California Strategic Plan for Suicide Prevention, including the California National Guard and the VA Medical Centers in the state.

Correctional Facilities and Law Enforcement

The periods of highest risk of suicide among individuals involved in the criminal justice system is in the first few weeks after incarceration or release from jail or prison (Pratt et al., 2006). Within the corrections system, increases in suicide risk have also been associated with negative events such as rape, violence, solitary confinement, bad news from home, and others (Florida Corrections Commission, 1999). There are many effective programs that offer models for partnership between the criminal justice and mental health systems, such as jail diversion and re-entry programs such as those funded by grants from SAMHSA. By building local partnerships both within the criminal justice system and at community re-entry, suicide risk among inmates can be reduced along with the

medical cost of treating acute problems, which will provide a safer setting for inmates as well as staff (American Association of Suicidology, National Conference of State Legislatures, 2007).

To address the mental health needs and suicide risk of individuals who were being released from jail, who were identified by the courts as repeat offenders, or were being discharged from an inpatient psychiatric facility, one community in Monroe County, New York developed a coalition of community care providers, the county mental health department, local criminal justice systems, the courts, and the university psychiatry department to reach out to these individuals and provided coordinated services. Individuals in the program received intensive case management, evaluation of medical and mental health problems, supervised housing, and other services. Outcomes of this project included no suicide attempts, assaults or other reportable incidents during the study period among subjects, and the reduction in jail and hospital expenses amounted to approximately three times the program's cost (American Association of Suicidology, 2003). The findings from research and data on the needs of this population provide strong support for implementing programs in jails and prisons as well as programs that support re-entry into the community.

Employers

Integrating suicide prevention into work settings is recommended to reach a large number of adults who may be at risk, but who are not currently utilizing or likely to seek out mental health services. Resources need to be developed and disseminated to employers that provide guidance about how to recognize and assist employees who may be exhibiting warning signs of suicidal behaviors, who are coping with family members or friends of individuals presenting with suicidal behaviors, or who are themselves survivors of suicide. Recently, the Partnership for Workplace Mental Health, which includes the American Psychiatric Association, the American Psychiatric Foundation, and business leaders, launched *Employer Innovations Online* (http://www.workplacementalhealth.org). This is a web-based, searchable data base that provides resources, models, assessment tools, and detailed information that employers can access to develop strategies to address workplace mental health issues (American Psychiatric Association, 2008). Another readily available resource is the National Business Group on Health, a national non-profit organization that provides information and resources on health and mental health issues in the workplace (SAMHSA, 2007).

Employers should be encouraged to access these resources as well as to build and maintain a directory of local prevention, treatment, and support services that are readily available, in a non-stigmatizing manner, to all employees. Another is to providing outreach and education about suicide prevention and mental health into existing employee support networks, such as Employee Assistance programs, to reach people who might not otherwise seek help.

Reducing Access to Lethal Means

The majority of suicide deaths that occur are the result of use of firearms. Research has shown that having a gun in the house is associated with higher risk of suicide among both adults and adolescents, and that regions of the country with high rates of gun ownership also have higher overall suicide rates (Miller et al., 2007; Grossman et al., 2005).   Using gun storage safety precautions such as storing guns unloaded and storing ammunition in a separate, locked container, are associated with lower numbers of both suicide deaths and unintentional injuries (Grossman et al., 2005). Studies of the impact of public policy toward more restrictive firearm legislation, such as Child Access prevention laws and others, have led to significant decrease in suicides rates (Kapusta et al., 2007; Webster et al., 2004). Public policies that restrict access to lethal means and educate people about how to safely handle potentially lethal materials – from firearms to medications – can save lives.

Information from the Suicide Prevention Resource Center indicates that multiple efforts are underway in other states to address access to lethal means. Maine, New Hampshire, and Oregon provide educational materials and training about screening for access lethal means in potentially suicidal patients who are in a primary care or emergency department setting, and in how to provide counsel about reducing access to them. Montana and Wyoming organize the distribution of free gun locks at community events.

To deal with the problem of bridge jumping, many communities have erected bridge barriers or are considering doing so. Barriers reduce ease of access to the area on the other side of the railing by increasing the height of the railing and/or adding nets or other structures that make a jump much less likely to occur.

Approaches to Address Workforce and Training

It is imperative to ensure that providers in multiple service fields are equipped to recognize and intervene when suicide risk is present. Equally imperative is the need to ensure that there are services to meet needs when they are recognized. This requires the development of training and service guidelines that target the specific concerns and opportunities for intervention that are present in different settings, from primary care to mental health clinics, classrooms, juvenile justice facilities, substance abuse treatment programs, to the venues served by law enforcement and probation officers.

Health, Mental Health, and Social Services

Unfortunately there are many missed opportunities for prevention and early intervention among people who are at risk of suicide. With standard or core training guidelines and service protocols, service providers will be better prepared to appropriately respond when suicide risk is present.

Two-thirds of individuals who committed suicide visited a physician in the month prior to their death, and up to 40 percent did so within a week of their death (Gaynes et. al., 2004). In one study of physician visits by patients presenting with either major depression or adjustment disorder, physicians asked questions about suicide in only 36% of visits (Feldman et al., 2007). Physicians were more likely to explore suicide if they had personal experience with depression or if the patient prompted discussion of suicide (2007). Furthermore, many physicians may avoid bringing up the topic of suicide because they feel unequipped to respond and do not want to risk worsening the situation (2007). Unfortunately, many health providers may be reluctant to ask questions to assess suicide risk because they do not feel adequately trained about procedures to consistently provide proper assessment, treatment, and management of suicidal patients and clients, or they do not know how to refer them properly for specialized assessment and treatment (Bongar, Lomax & Harmatz, 1992; Ellis and Dickey, 1998; Ellis, Dickey & Jones, 1998; Feldman et al., 2007). Research suggests that educating physicians to recognize and treat depression and other conditions that present a heightened risk of suicide, and providing them with the tools to consistently and properly address suicide, can prevent suicide deaths (Feldman et al, 2007; Mann et al, 2005).

In addition, about 45 percent of individuals who die by suicide had contact with a mental health professional within a year of their death (Pirkis & Burgess, 1998). At present, mental health professionals in California do not have a standard competency or licensing requirement that specifically focuses on assessing, treating, and caring for patients at risk for suicide. Health clinics, i.e. primary care and prenatal care, mental health centers, emergency response systems, crisis centers, and alcohol and drug programs are key access points. Personnel in these systems need to have consistent guidelines for effective assessment and treatment interventions.

Staff working in social services, child protection, foster care, and juvenile justice interact on a daily basis with high risk youth, and are in a critical position to identify and intervene when adverse childhood experiences have taken place or suicidal ideation and behavior are present. To appropriately identify and reduce suicidal behavior, staff in these systems needs to be trained in prevention and early intervention strategies that are effective for the populations they serve.

A system of suicide prevention must include continuity of care after discharge from in-patient settings and emergency departments, when individuals may be at

particularly high risk of suicide. There is a need for service protocols that provide follow-up care for these vulnerable individuals to ensure that they get the support they need once their acute medical or psychiatric needs are met. Emergency room personnel come into contact with individuals with self-inflicted injuries, many of which may have been intentional. However, there is variability in emergency room policies and procedures to link patients with professional mental health assessments, and follow-up services (Baraff et. al., 2006).

Law Enforcement

Law enforcement officers are often the first on the scene when a suicide crisis emerges; they also come into contact with family members and loved ones of individuals who have committed suicide.   There are several evidence-based training models for law enforcement officers to educate them about the signs of mental health problems and suicide risk and how to appropriately intervene while maintaining public safety (Lyons, 2007). For example, the Crisis Intervention Team (CIT) provides officers with training that includes a simple eight question assessment tool along with techniques for de-escalating a crisis. CIT has been implemented in locations nationwide. Many local law enforcement agencies report that it is even more effective than a traditional mental health or mobile crisis response because police are typically first responders that are on the scene within 10 to 15 minutes (Reuland, 2004). CIT has also been shown to reduce officer injury rates five-fold (Dupont et al., 2000).

Establishing Training and Service Guidelines

A substantial precedent exists for establishing guidelines for training and service in selected occupations. For example, the American Psychiatric Association has developed guidelines for mental health professionals, and the Suicide Prevention Resource Center (SPRC) has developed a tool for suicide prevention programs within law enforcement departments. Youth Suicide-Prevention Guidelines for California Schools (2005) assist schools in developing and implementing plans for youth suicide prevention, intervention and aftermath.   The SAMHSA Campus Suicide prevention grant program and the SPRC have developed materials that support the development of guidelines in campus settings. For example, Promoting Mental Health and Preventing Suicide in College and University Settings (SPRC, 2004) provides recommendations for institutions of higher learning to assist implementation of suicide prevention programs. Finally, SAMHSA and the American Association for Suicidology have developed guidelines for developing protocols for discharge from emergency rooms and providing follow-up care for individuals who have attempted suicide (Deisenhammer et al., 2007; National Strategy for Suicide Prevention, 2001).

Gatekeepers are defined as those who regularly come in contact with individuals contemplating suicide. These individuals should be trained to recognize the signs and risks of suicide and how to appropriately intervene.   The NSSP (2001) identifies the following key "gatekeeper" occupations:

- Teachers and school staff
- School health personnel
- College teachers and staff
- Police officers
- Correctional personnel
- Supervisors in occupational settings
- Clergy and faith-based community leaders
- Natural community helpers, such as promotoras, senior center staff and volunteers, and staff from cultural resource centers
- Hospice and nursing home staff and volunteers
- Primary health care providers
- Mental health care and substance abuse treatment providers
- Emergency health care personnel.

The list above is general; training strategies should consider the target population in the planning process and ensure that individuals most likely to interact with those at risk in the community are included.

Statewide Coordination of Suicide Prevention

In order to achieve maximum benefit and efficiency and to minimize duplication of efforts throughout our large state, it is imperative that there is a centralized, coordinating body for the various suicide prevention activities that can be responsible and accountable for effectively reaching and serving the diverse populations of California.   Establishment of a statewide office would provide a single point of contact and a central point of dissemination of information, resources, and data.   It would serve as a liaison with national partners such as the SPRC and SAMHSA, as well as other states, to ensure that activities build upon resources and materials where they already exist, and to receive expert consultation on plans and activities. This strategy has been effective in other states. Maryland implemented a model state prevention and awareness program and now has the fifth lowest suicide rate in the nation. Colorado has established a similar office resulting in increased federal funding for suicide prevention and successful coordination of training for gatekeepers throughout the state (Westray, Maryland Suicide Prevention Model; State of Colorado, 1998).

A centralized coordinating office of suicide prevention would support integration of resources and activities for suicide prevention through various state and county level systems and organizations. It would centralize coordination of strategic suicide prevention, intervention, post-vention and research activities throughout the state, including dissemination of model training curricula and service guidelines targeted to different professional groups and settings.

The Office would oversee the development of a research agenda that would fill gaps in knowledge and data about suicide and suicidal behavior of all Californians, and evaluation of interventions to ensure they are effective. It would coordinate periodic review and update of the Strategic Plan for Suicide Prevention by a committee of individuals with expertise and direct experience with suicide and suicide prevention. This review would involve tracking selected indices of suicide behavior and incidents over time to provide a layer of accountability.

The Office would provide statewide leadership in developing learning communities among the counties, and among stakeholders within the counties, through such activities as disseminating information for community planning, supporting learning communities with various consortia (e.g. college counseling centers, mobile crisis response, help lines, mobile crisis response, and senior centers), conducting leadership training conferences to build capacity and develop emerging leaders, and linking statewide office coordination to county coordination.

Public Awareness Campaigns and the Media

Stigma is a powerful and deeply engrained part of our culture. Negative portrayals of individuals with mental illness as violent or hopeless, and sensational coverage of a tragic event contribute to stigmatizing attitudes in the general public, which often leads to discrimination. Unfortunately, these depictions of people with mental health problems as unpredictable and even dangerous are common in films, television, and the news media. When not countered with education and awareness about the facts of mental illness, these stories fuel people's fears and promote self-stigma among individuals with a mental illness diagnosis (SAMHSA ADS Center; Jamison 2006). Stigma is also evident in many policy decisions ranging from health insurance coverage and employment discrimination to research priorities (Jamison, 2006).

Nearly two-thirds of those who have a diagnosable mental illness do not seek treatment because of fears of stigma and discrimination (Surgeon General's Mental Health Report, 1999 as cited in National Conference of State Legislatures). Nationally, SAMHSA has launched an ongoing, national anti-stigma campaign that offers resources to states to develop their own, targeted anti-stigma materials. There are also localized stigma and discrimination reduction projects under way in California through Mental Health Services Act funding. Development of a statewide suicide prevention campaign should complement local and national anti-stigma campaigns, peer-to-peer programs, and personal contact strategies that effectively increase awareness and influence help-seeking behaviors (National Mental Health Awareness Campaign, 2006).

There is a need for education about the warning signs of suicide and to deliver a clear and consistent message about how to respond to suicidal behaviors for diverse population groups.   Such activities include designing messages that educate the public that suicide is preventable, raising awareness of the populations at risk, forging new and creative approaches to engage community partners, and promoting community-based support systems and cultural-specific ways of healing. Use of multiple media channels, including ethnic media, is necessary to ensure the message is far reaching. Linking with national campaigns, such as National Suicide Prevention and Awareness Week and National Depression Screening Day, should also be considered to maximize impact by reinforcing the messaging.

Public health has successfully used statewide media campaigns to promote public awareness and influence health behaviors on various topics. The California Tobacco Control Program (CTCP) was formed after Proposition 99 passed in 1988, providing California with the funds to initiate a comprehensive anti-tobacco program.   The CTCP found that the most efficient way to reach its goal of decreasing tobacco-related deaths and disease is to implement initiatives statewide that seek to change social norms that influence individual behaviors (California Department of Public Health, Tobacco Control Section, 2006, CDPH/TCS 2006).   The CTCP used an approach of countering negative influences, including smoking advertising and marketing, by depicting tobacco use as undesirable and socially unacceptable (CDHS/TCS 2006). The campaign also supports smoking cessation efforts through a Helpline and community-based programs. Finally, the campaign includes a media education component to offset depictions of smoking as acceptable in movies and to counter tobacco industry advertising. Some of the results of the program include an increased desire and intention to quit among smokers, and the smoking prevalence in the state has declined by 33.6% since its inception (CDPH/TCS 2006).

Research indicates that exposure to suicide through the media may increase the risk of suicide, a phenomenon called "contagion" (National Strategy for Suicide Prevention, 2001). When the number of stories about suicides increases, or a death is reported at length or featured prominently, the contagion effect can lead to an increase in suicides (Hassan 1995; Phillips et al, 1992). Guidelines to inform the media can impact the decisions reporters make about how to cover suicide incidents in a way that balances public safety with what is newsworthy (American Association of Suicidology; Pirkis et. al. 2007). Media coverage should be used as a positive tool to promote greater understanding of the risks and protective factors and how to get help.

Research and Evaluation

The availability of reliable local and state data on suicide provides an incomplete picture of the true magnitude of the problem in California. For example due to the paucity of disaggregated data, we know very little about how suicide impacts

certain ethnic population groups. While information is available about a number of effective and promising suicide prevention practices, much more needs to be learned about programs specifically designed to serve certain population groups. With these substantial gaps in knowledge about how suicide impacts Californians and how to better prevent it, a research agenda must be established in order to better design responsive policies and effective programs towards reducing the impact of suicide throughout our state.

California is a large, diverse state with unique demographics. To strengthen suicide prevention, there is a need to increase knowledge about the causes and types of suicide, the stages of suicidal behaviors (e.g., ideation, planning, attempt, and aftermath), and the impact of exposure to trauma, such as adverse childhood events, historical trauma[7], intergenerational conflicts[8], and trauma history within an immigrant's country of origin. Understanding of the role of acculturation in the development of risk and protective factors in immigrant communities need to be enhanced. More information is also needed about the relationship between suicide and postpartum depression, homicide, and other factors. Knowledge is also needed about risk and protective factors based on gender, age, disability, sexual orientation, homelessness, rural location, military services, and other factors related to identify.

Not all aspects of a research design for suicide and suicide prevention in California would need to be developed anew. Multiple state agency databases exist that can be coordinated, connected, and enhanced to fill gaps in knowledge. Additionally, California hosts a wealth of world class research universities and institutes that could bring expertise to the table. There are existing surveys in California that can be expanded to provide a broader picture of suicidal behavior. These surveys include the California Healthy Kids Survey for middle and high schools, the California Behavioral Risk Factor Surveillance instrument, the California Health Interview Survey and others.

Accurate and complete information, including disaggregated racial and ethnic data, about suicide prevalence and prevention need to be widely accessible to the public and to policymakers to inform service and system improvements. Nationally, one persistent challenge is that the information that flows into reporting systems may not be uniform and may come from different places, for example the death certificate may ultimately be completed and signed by medical examiners or coroners, or by a public official in the legal system (Goldsmith, 2001). This may result in differences in how suicide deaths are determined and recorded.   One solution to this is a single set of criteria for suicide deaths that are widely used by both medical and legal systems. Another is to expand or link the data systems that already exist to gather more detailed suicide data, such as the Center for Health Statistics, Violent Death Reporting System, hospital

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[7] The collective emotional and psychological injury both over the life span and across generations, resulting from a cataclysmic history of genocide
[8] Conflict between generations related to the acculturation process of immigrant families.

emergency department, and crisis center admission databases that can link data from other systems, such as mental health, alcohol and drug programs, corrections, and school districts.

There are examples of enhanced databases informing policy and practice in ways that address suicide prevention. California is one of 17 states currently participating in the CDC's National Violent Death Reporting System that links data from death certificates, police reports, and medical examiner or coroner reports to provide a better understanding of the prevalence and factors associated with violent deaths, including suicide (SPRC, NVDRS and Suicide fact sheet). Information from this database can be used to identify trends and risk factors that can inform program and policy decisions to more effectively prevent suicide. NVDRS can also be used to identify additional information that needs to be collected to pinpoint the factors associated with suicide. This database is scheduled to be available on line in spring 2008. Some examples of how states have used the NVDRS include:

- *Maryland*: although suicide rates are 4 times higher among men, many women but few men were receiving mental health services at the time of their death. Therefore improvements to the mental health system in Maryland alone will not solve the problem; strategies need to be developed to reach out to at-risk men

- *South Carolina*: two thirds of youths who committed suicide were involved in the juvenile justice system; this NVDRS finding led to protocols in the system to more effectively screen at-risk youth

- *Oregon*: when state data revealed that 37 percent of older adults visited a physician in the month prior to their death, resulting in a statewide plan to improve identification and intervention among medical professionals. In response to the very high suicide rate among older adults in the state, Oregon expanded the database to collect additional, more targeted information relevant to older adults.

- *Rhode Island*: many suicide deaths occurred when individuals overdosed on their own prescription medications, raising concerns that they may not have received adequate counseling about how to use their medications. The database was expanded to collect information about the specialty of their prescribing physicians to identify groups of medical professionals that may be targeted for more education about the risk of suicide.

The lack of evaluation research on suicide and suicide prevention is one of the most important problems to address in ensuring that limited resources are used effectively and to provide a layer of accountability to legislators, funders, scientists, survivors, and the general public (Suicide Prevention Action Network, 2001). Efforts to expand statewide data systems should be complemented by

strategies to increase local capacity for data collection, surveillance reporting, and information dissemination that support local program development. This may involve devising processes to engage coroners and medical examiners in designing training in investigation techniques and data reporting that will improve knowledge of suicide. Use of community-based participatory research (Patten et al, 2006) and action research methods, including longitudinal studies and qualitative methods such as focus groups, ethnography, and oral histories, are also important methods that can be developed to clarify how we can improve suicide prevention strategies.

Finally, there is a need to identify and disseminate models for evaluating suicide prevention programs and activities to increase the number of evidence-based programs in California. This includes collecting outcome measures that are consistent and relevant to improve programs and the experiences of service users. Effective culturally and linguistically appropriate approaches to suicide prevention need to be strengthened. Alongside statewide stigma reduction efforts, there needs to be an evaluation of how social norms change and their effects on rates and prevalence of suicidal behavior. There are several resources that support the dissemination of evidence-based suicide prevention practices, such as the Suicide Prevention Resource Center's Best Practices Registry and the SAMHSA National Registry of Evidence Based Programs and Practices (NREPP). The criteria required for inclusion in these registries (i.e., proven, promising, emerging) are reliable sources of information about the practice, including whether it has been tested in diverse population groups.

Part 3: Every Californian is Part of the Solution: The California Strategic Plan for Suicide Prevention

Strategic Directions and Recommended Actions

The plan is organized by two levels of focus for suicide prevention: strategic directions and recommended actions.

Strategic Directions are grouped into four key concept areas:
- Create a system of suicide prevention,
- Implement training and workforce enhancements to prevent suicide,
- Educate communities to take action to prevent suicide, and
- Improve suicide prevention program effectiveness and system accountability.

Strategic Directions are broad levels of focus that serve as the central aim to be addressed by more specific Recommended Actions. These actions are not intended to be an exhaustive list, but to reflect the priorities that have emerged as critical to reduce suicide and its tragic consequences on individuals, families, and communities throughout California.

In combination, the Strategic Directions and Recommended Actions are intended to create a system of suicide prevention that builds on existing infrastructure, expands capacity of co-existing systems, and identifies and fills gaps in services and programs.

In keeping with the spirit of the Mental Health Services Act, it should be noted that the following **five core principles** are embedded in all levels of planning, service delivery, and evaluation identified in the Californian Strategic Plan for Suicide Prevention:

Core Principle 1. Implement culturally competent strategies and programs that reduce disparities.

In order to be effective, systems, organizations, and services for suicide prevention must embrace behaviors, attitudes, and policies that are compatible with diverse belief systems and customs. Reducing disparities in the availability, accessibility and quality of services for racial, ethnic, and cultural groups that have been historically underserved is a key goal. Planning and service improvements processes should involve members of the racial, ethnic, and cultural groups that are targeted.

Core Principle 2. Eliminate barriers and increase outreach and access to services.

Potential barriers must be addressed in designing and implementing outreach and service programs in order to ensure improved access for all of California's diverse populations and communities. Systems, policies and practices must be accessible to those with limited English proficiency, with low literacy skills, and with vision, hearing, and cognitive disabilities. Information, programs, and materials need to be accessible and available in a variety of languages and formats.

People who live in rural areas often must travel significant distances to access needed services. Many other individuals are isolated by physical and/or psychiatric disabilities, including age-related disabilities that render them homebound or marginalized from needed support systems.

Core Principle 3. Meaningfully involve survivors and the family members, friends, and caregivers of those who have completed or attempted suicide, and representatives of target populations for planning and services.

Those who have survived a suicide attempt and their family members, friends, or caregivers bring important personal experience and unique perspectives to identifying service needs and gaps in the system and to delivering services. Additionally, when service improvements are underway that target specific populations, it is crucial that representatives of those groups are an integral part of the planning process. Their involvement in all aspects of planning and implementing prevention activities is essential. Peer support and education are invaluable components of a comprehensive system for suicide prevention.

Core Principle 4. Use evidence-based models to strengthen program effectiveness and build upon existing effective programs.

Many programs and practices exist that have demonstrated effectiveness, broadly or within specific populations. Attention should be given to replication and dissemination or consideration of adaptation of these effective program models and promising practices. Prevention program design should include consideration of how evaluation can be used as a management tool to strengthen and improve programs. Data can be an invaluable tool to garner support for program implementation at all levels.

There are many programs and providers currently offering needed and effective services to prevent suicide. Where such promising service or program models exist, the focus should be on coordinating and building upon their foundation towards the development of a more comprehensive system of suicide prevention.

Core Principle 5. Broaden the spectrum of partners involved in a comprehensive system of suicide prevention.

To achieve the vision that "Every Californian is Part of the Solution," it is critical that long term partnerships be developed with a broad range of partners that transcends the traditional mental health system. This may include the business community, ethnic and cultural community-based organizations, senior centers and aging services, the spiritual and faith community, private foundations, schools and institutions of higher education, health and human service organizations, criminal and juvenile justice entities, and military partners such as Veterans Affairs and the National Guard.

Strategic Direction 1: Create a System of Suicide Prevention

Increase collaboration among state and local agencies, private organizations and communities by coordinating and improving suicide prevention activities and services throughout the state.

Recommended Actions at the State Level

1.1   Establish a state Office of Suicide Prevention.

1.2   Expand the number and capacity of accredited suicide prevention help lines based in California and create a statewide consortium.

1.3   Convene and facilitate topic-specific working groups that will address specific populations and issues, and develop, adapt, and disseminate resources and other materials that address the topic.

1.4   Identify and implement needed improvements in confidentiality laws and practices to promote safety, health, wellness, and recovery.

1.5   Identify and initiate actions to reduce access to lethal means.

Recommended Actions at the Local Level

1.6   In each county, appoint a liaison to the state Office of Suicide Prevention, and convene an appropriate existing or new suicide prevention advisory council to collectively address local suicide prevention issues.   Members of the advisory council should also serve on suicide review teams (See Recommended Action 4.1). Membership should include a diverse range of local stakeholders, including local government and nonprofit agencies, tribal representatives, community leaders, survivors and family members, and mental health client advocates.

1.7   Develop a local suicide prevention action plan with the input of a diverse, representative group of stakeholders, including the suicide prevention advisory council (See Recommended Action 1.6), and report on suicide prevention activities in existing county reporting mechanisms, such as those for Mental Health Services Act components and county cultural competence reports.

1.8   Deliver services that reflect integration among systems providing crisis intervention, including health, mental health, emergency response, and help lines.

1.9　　Integrate suicide prevention programs into K-12 and higher education institutions; existing community-based services for older adults; employee assistance programs and the workplace; and the criminal and juvenile justice systems.

1.10　　Develop and promote programs that appropriately fill service gaps for historically underserved racial/ethnic groups and other high risk populations.

In order to create a system of suicide prevention, coordination and collaboration at the state and local levels is necessary to address needed improvements in access and availability of services to diverse populations. This may be achieved by developing a network of public and private organizations and implementing multiple approaches, from policies that impact the entire state to effective individual programs. The public and private partnerships should include: employers, health and mental health providers, the insurance industry, community-based and ethnic-based organizations, local education agencies, spiritual and faith based organizations, consumer, family, youth and peer support advocacy groups, and other community leaders.

A state Office of Suicide Prevention would:

- Engage public partners including the Department of Mental Health, Department of Public Health, Department of Managed Health Care, the Managed Risk Medical Insurance Board, Department of Health Care Services, Department of Alcohol and Drug Programs, Department of Social Services, Department of Education, Department of Aging, California National Guard, Department of Veterans' Affairs, the Department of Corrections and Rehabilitation, and other appropriate provider and professional groups to expand and integrate suicide prevention efforts across systems;
- Coordinate activities with a statewide impact, such as examination of confidentiality laws and policies governing access to lethal means;
- Serve as a clearinghouse of information about research findings, best practices, and community planning by employing internet and other technology to facilitate dissemination and promote transparency and accessibility;
- Convene special topics workgroups to provide continuous guidance and feedback on implementation of the statewide strategic plan.

Building a statewide consortium of suicide prevention help lines needs to begin with conducting an assessment to identify and address gaps in services, such as multiple language capacity, ability to connect individuals with local resources; and readiness to provide training and technical assistance to support existing help lines to become accredited. This effort should account for and coordinate with existing resources such as peer warm lines. To underscore the importance

of this issue, it is recommended that a condition of public funding for suicide prevention help lines be that the help lines obtain and maintain accreditation.

Counties need to enhance links between systems and programs to better address gaps in services and identify resources to support local solutions to reducing suicide in their communities. An essential step toward establishing a strong foundation is the development of a local suicide prevention action plan through an inclusive community process that includes representatives from public and private agencies, community-based and ethnic-based organizations, and advocates of mental health clients and survivors. The plan should establish clear protocols for communication between systems and providers, identify specific target population groups, create and monitor an effective crisis response system, work with the state Office of Suicide Prevention to coordinate a periodic review of the county's progress and to update the local action plan. Counties are encouraged to explore opportunities for using local discretionary funds to provide incentives to expand suicide prevention efforts to reduce the incidence of suicidal behaviors and suicide deaths.

Strategic Direction 2: Implement Training and Workforce Enhancements to Prevent Suicide

Develop and implement service and training guidelines to promote effective and consistent suicide prevention, early identification, referral, intervention, and follow up care across all service providers.

Recommended Actions at the State Level

2.1   Recommend, develop, evaluate, disseminate, and broadly promote suicide prevention service and training guidelines and model curricula for targeted service providers, including peer support providers, in California.

2.2   Expand suicide prevention training for selected occupations and facilities using long term approaches, such as embedding suicide prevention requirements in existing licensing, credentialing, graduate and professional program requirements, and continuing education programs.

Recommended Actions at the Local Level

2.3   Establish annual suicide prevention training targets that identify number of individuals, occupations, and models, including peer support, and implement training plans that meet these targets.

2.4   Increase the priority of suicide prevention training through outreach and by disseminating state guidelines. Using an inclusive process for input, tailor and enhance state guidelines as necessary to meet community needs.

At minimum, occupations selected for training should include:
- Primary care providers, including physicians and mid-level practitioners;
- Emergency response personnel, including police officers and sheriffs, emergency department staff and emergency medical technicians;
- Licensed mental health and substance abuse professionals and staff in outpatient and community-based settings as well as psychiatric facilities;
- Social workers and staff in child protective services and foster care;
- Adult and juvenile system corrections and jail officers and probation and parole officers;
- K-12 administrators, credentialed faculty in elementary, middle schools and high schools and in colleges and universities.

Service and training guidelines on suicide prevention, early intervention, treatment and follow-up care needs to be readily available for occupations and settings where individuals are most likely to come into close contact with persons at risk for suicide, in crisis, or following an attempt. These guidelines should

increase understanding of protective and risk factors; improve suicide risk assessment, treatment, and after care management care and services; and reduce stigma and discrimination. Guidelines should also address cultural issues to increase understanding of suicide prevention and intervention in diverse population groups.

Service and training guidelines should include direction and recommendations for:

- Follow-up care that establishes specific actions to be taken when a person who has made a suicide attempt or was treated for self-inflicted injuries is being discharged from an emergency room, urgent care center, hospital, or at the close of a visit with a physician/health care staff;

- Promotion of the development of quality care and utilization management guidelines in health insurance plans for approval of services and effective response to suicide risk or suicidal behavior;

- Implementation of promising practices such as Crisis Intervention Teams; and

- Incentives for community organizations to provide suicide prevention training and to employ trained "gatekeepers".

To meet local needs, adaptation of guidelines should engage a broad range of community stakeholders, including survivors and representatives of the diverse groups targeted for training such as different racial/ethnic groups.

Strategic Direction 3: Educate Communities to Take Action to Prevent Suicide

Raise awareness that suicide is preventable and create a supportive environment for suicide prevention.

Recommended Actions at the State Level:

3.1   Launch and sustain a suicide prevention campaign with messages that have been developed and tested to be effective for diverse communities and that address warning signs, suicide risk and protective factors and how to get help.

3.2   Coordinate the suicide prevention campaign with a multi-faceted social marketing campaign to eliminate stigma and discrimination toward individuals with mental illness or co-occurring disorders and their families that may present a barrier to accessing needed services.

3.3   Educate and engage the news media, including ethnic media and the entertainment industry to promote balanced and informed portrayals of suicide, mental illness, and mental health care services that support suicide prevention efforts.

Recommended Actions at the Local Level

3.4   Build grassroots outreach and engagement efforts to coordinate with the statewide suicide prevention campaign, tailoring messaging and activities to best meet diverse community needs.

3.5   Create opportunities to promote greater understanding of the risks and protective factors related to suicide and how to get help by engaging and educating local media about their role in promoting suicide prevention.

3.6   Educate family members, caregivers and friends of those who have attempted suicide, individuals who have attempted suicide and natural community helpers, including youth, to recognize, appropriately respond to, and refer people demonstrating acute risk factors.

3.7   Develop and disseminate directory information on local suicide prevention and intervention services that include information about how and where to access services and provide techniques on how to deal with roadblocks. Ensure that this information is available through multiple venues to providers, gatekeepers, and help lines.

3.8   Support peer support and client-operated services models as a part of suicide prevention and aftercare services.

Strategic Direction 4: Improve Suicide Prevention Program Effectiveness and System Accountability

Improve data collection, evaluation, and information sharing with the public to advance suicide prevention efforts and measure progress.

Recommended Actions at the State Level:

4.1   Develop a research agenda on suicide and suicide prevention, specific to California, to support more data-driven policies and evidence-based programs.

4.2   Coordinate with the Office of Suicide Prevention and county liaisons to make data easily accessible to the public at large and regularly provide the data to policy makers at all levels to improve understanding of suicide and enhance prevention efforts for all population groups.

4.3   Identify or develop methodologies for evaluating suicide prevention interventions, including community-based participatory research methods, and provide training and technical assistance on program evaluation to the counties and local partners.

Recommended Actions at the Local level:

4.4   Increase local capacity for data collection, reporting, surveillance, and dissemination to inform program development and training, including community-based participatory research methods.

4.5   Work with coroners and medical examiners to determine how to enhance reporting systems to improve the consistency and accuracy of data about suicide deaths.

4.6   Encourage counties to establish two coordinated suicide review teams: a case review team and a policy action team.

Evidence-based practices should be tested and adapted as necessary for effectiveness in a variety of community settings and/or among diverse populations groups. Methodologies should be developed to promote the evaluation of promising community models to build their evidence base. Finally, research projects should be designed that expand and deepen knowledge about how suicide impacts diverse communities.

In counties, the suicide case review team should consist of representatives from the Office of the Coroner and/or Medical Examiner, law enforcement, mental health and health agencies, schools and universities, and other appropriate agencies that have legal access to confidential information. The case review team would complete clinical and forensic review of cases.

The policy action team would provide recommendations for translating data and case review findings into effective, data-driven policies and programs. The policy action team would consist of representatives from the local suicide prevention advisory council (See Recommended Action 1.5), government and private organizations, tribal representatives, advocates, clients of the mental health system and their families, and other experts concerned with suicide.

The case review and policy actions teams should be coordinated and communicate regularly to ensure a two way flow of information and expertise. The teams will collaborate to report findings and data to the communities, including de-identified stories to put a "human face" on the suicide statistics.

Part 4: Next Steps

The Statewide Strategic Plan has identified four major strategic directions and 28 recommended action steps towards reducing the number of suicide deaths and the incidence of suicidal behaviors in California. The working plan calls for a tremendous effort at many different levels involving multiple partners in a coordinated fashion to identify and successfully achieve the necessary program, policy and system improvements.

The Advisory Committee recognized that in order to succeed in both the short and long term it is essential during the first phase of implementation to establish a solid foundation upon which to build. Further, the Advisory Committee acknowledged the need to be deliberate and sequential in implementing the recommendations (e.g., the need to enhance the capacity of the workforce before launching a major campaign that would increase the demand for services). Lastly, the Advisory Committee implored that the funding to support the ongoing services be at a sufficient level and sustained.

Success will be achieved through a collective and well integrated effort; it cannot be solely dependent upon one funding source nor can the responsibility be shifted to any one entity. The theme, Every Californian is Part of the Solution, must ring true throughout the implementation of the strategic plan if indeed lives are to be saved and suicidal behaviors decreased.

The Office of Suicide Prevention, proposed to be housed in the California Department of Mental Health (DMH), would serve as a coordination point for addressing many of the recommended actions stated in this plan. However, it is expected that leadership and support from other public and private agencies will also play a paramount role. Thus, in conjunction with a number of key partners, the Office of Suicide Prevention would develop a detailed work plan to initiate its operation.

In addition, DMH and the Mental Health Services Act (MHSA) Oversight and Accountability Commission, with support from the California Mental Health Directors Association, have recommended that counties direct $14 million each year for four years for statewide suicide prevention projects. The Mental Health Services Oversight and Accountability Commission, County Mental Health Directors and DMH, with stakeholder input, will collaboratively determine how these funds will be spent. Counties may also direct a portion of their local MHSA funds to suicide prevention efforts. A portion of the funding has been earmarked for Student Mental Health Initiative grants for K-12, community colleges and universities.

To launch this concerted effort to prevent suicide and suicidal behavior in California, the following activities should be considered for the initial implementation phase:

Strategic Direction 1: Create a System for Suicide Prevention

County level infrastructure support

A.   Establish the infrastructure and provide support for linking county level advisory councils dedicated to developing the local integrated suicide prevention system.

B.   Establish and maintain a collaborative relationship among the state and county liaisons.

C.   In conjunction with the Statewide Training and Technical Assistance project for Prevention and Early Intervention, survey training and technical assistance needs of the counties. Develop a plan for addressing and providing the necessary support utilizing distance-learning modalities, online services, and other effective methods.   Secure necessary resources and partnerships to expand available support. Evaluate and reassess needs and progress periodically.

D.   Collect data and report on the local activities being undertaken. Establish the baseline of the targeted policy, program and system improvements.

Expanded venues for suicide prevention assistance

E.   Establish a statewide consortium of fully accredited 24-hour suicide prevention help lines to expand access to standardized services throughout the state and to ensure full multilingual crisis coverage for all Californians. Assess the current status of coverage and accreditation.

F.   Enhance the database for monitoring, tracking, evaluating, and reporting suicide prevention help line calls in California (e.g. collect information about calls and outcomes by age, sex, county location, language, etc.).

G.   Explore and support additional functions for the accredited suicide prevention help lines such as training centers for various occupations and professions including peer support providers and after-care service providers.

H.   Research and invest in additional venues and formats (including the internet, 211 lines, and other age/culturally-appropriate means) such as web-based self-help services targeted to youth as means for expanding access to information on local suicide prevention and early intervention services.

I.   Develop and maintain a website for the Office of Suicide Prevention that provides links to the abundant sources of reliable information. Identify and develop additional new information needed to appropriately address the needs of all Californians.

Statewide system improvements

J.   Establish a consortium of state-level organizations to address the integration of effective suicide prevention programs into existing service systems such as:
- K-12 and higher education (in conjunction with the MHSA Student Mental Health Initiative)
- Services for older adults
- Criminal and juvenile justice systems
- Veteran services (in conjunction with Federal agencies)
- Health and mental health care (in conjunction with health care reform)

K.   Issue an action plan that includes an assessment of the current level of activities, identification of short and long term objectives, and recommended next steps. Monitor progress.

Strategic Direction 2:
Implementing Training and Workforce Enhancements to Prevent Suicide

A.   Assess the current criteria and standards for service and training guidelines that address suicide prevention, early intervention, treatment, and suicide attempt follow up care for California's diverse population.

B.   Begin with a review of the various occupations and professions identified in the Plan to identify the first cohort of training programs to be assessed and enhanced. Identify opportunities for training program enhancements and work cooperatively with appropriate agencies to implement needed improvements.

C.   Recommend, develop and broadly promote standard service and training guidelines for targeted service providers, including peer support providers, in California. Review licensing and credentialing processes to assess viability of new training requirements.

D.   Identify barriers and provide support and technical assistance to address challenges. Document actions taken.

Strategic Direction 3:
Educate Communities to Take Action to Prevent Suicide

A.   In conjunction with other Mental Health Services Act (MHSA) social marketing efforts (e.g., the proposed $40 million MHSA stigma and discrimination reduction campaign), develop and implement a multi-faceted, multi-language campaign that includes personal empowerment strategies and messages specifically designed and pilot-tested to positively influence help-seeking behaviors and reduce suicidal behaviors.

B.   Obtain the necessary social marketing expert consultation to design, test, and launch the suicide prevention campaign.

C.   Develop a vigorous evaluation component to track and monitor the statewide effort.

Strategic Direction 4:
Improve Suicide Prevention Program Effectiveness and
System Accountability

A.   Working collaboratively with other local, state and national entities, develop a California-specific research agenda on suicide and suicide prevention to support more evidence-based policies and programs in key areas such as those appropriate for specific ethnic/cultural or age groups, that are gender-specific, that address child trauma, and that have effective application in schools and other settings.

B.   Work to improve the collection and reporting of data as well as the systems for surveillance for a better understanding of the suicide trends and rates, and the impact of protective and risk factors among California's diverse population groups which can lead to more appropriate policies and programs.

C.   Establish a system for monitoring and tracking national, state and local policy changes and system improvements leading to a reduction in suicidal behaviors and suicide deaths in California.

D.   Develop and issue data reports on special topics/specific target populations by ethnicity, age and other factors to enhance programs and service delivery.

E.   Periodically review progress and reassess direction.

Appendix A: Glossary

(PLACEHOLDER)

Appendix B: Draft References (under revision)

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